Department of HUMAN SERVICES

Health Home Learning Collaborative

Health Home Services and Roles

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This training is a collaborative effort between the Managed Care Organizations and Iowa Medicaid Enterprise

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AGENDA

1. Introductions
2. Home Health Services and Roles……Bill Ocker, Iowa Total Care
   - Review the roles of each team member of the Health Home as it is stated in the SPA. Discuss overlap of services and roles. Also will touch on the role of the Health Home when a member has a wavier.
3. Questions/Open Discussion……All

   (Open discussion on current issues or barriers, potentially leading to future monthly topics)

   Coming up:

   - *April 26, 2021, Spring Learning Collaborative, Benefits of Health Homes/Interventions for members with SMI/SED*, Amerigroup
   - *May 17, 2021, Transitions in Care (inpatient hospitalization, PMIC, skilled nursing, re-entry / jail to community),* Iowa Total Care
   - *June 21, 2021, Assessment Process (Engaging members in CCHH and mental health / physical health services, member retention, importance of a good assessment, motivational interviewing), risk stratification, and workflows,* Amerigroup

Logistics

- Mute your line
- Do not put us on hold
- We expect attendance and engagement
- Type questions in the chat as you think of them and we will address them at the end.

Learning Objectives

- Participants will be able to define each role performed in the Health Home
- Participants will be able to identify the scope of work and activities performed by each role within the HH

Authority: ACA Section 2703

- Option to submit State Plan Amendment (SPA) depicting a health home model targeting chronic conditions:
  - Primary Care SPA:
    - Approved July 1, 2012
  - SPMI Population SPA (Mental Health focus):
    - Adults and Kids, SOC approach
    - Effective date July 2013
    - Phased-in by county between July 1, 2013-July 1, 2014

Chronic Condition Health Home PMPM Fee Schedule

Tier	Procedure Code	Modifier	PMPM Rate	Health Home Service	Informational Only Procedure Codes
1 (1-3 CC)	S0280	U1	$13.48	Chronic Care Management	G0506
2 (4-6 CC)	S0280	TF	$26.96	Care Coordination	G9008
3 (7-9 CC)	S0280	U2	$53.91	Health Promotion	99439*
4 (+10 CC)	S0280	TG	$80.87	Comprehensive Transitional Care	G2065
				Individual &Family Support Services	H0038
				Referral to Community and Social Support Services	S0281

*99439 replaces G2058 for Health Promotion for dates of service beginning January 1, 2021.

CCHH And Waiver

- When the member receives care coordination from a Community- Based Care Manager as a Home and Community-Based Waiver Service or Service Coordination through the MCO, the Health Home must collaborate with Community- Based Case Manager or Service Coordinator to ensure the care plan is complete and not duplicative between the two entities.

- Additionally, Lead Entities are contractually required to ensure non-duplication of payment for similar services; the State review and approves Lead Entity non duplication strategies and conducts ongoing monitoring to assure continued compliance.

- If the individual is already enrolled in an Integrated Health Home for members with a Serious Mental Illness or Serious Emotional Disturbance, must choose between the Chronic Condition Health Home and the IHH. A member cannot be in more one Health Home at the same time. Members in the Health Home will have state plan services coordinated through the Chronic Condition Health Home Provider.

COMPREHENSIVE CARE MANAGEMENT

Comprehensive Care Management

- Outreach and Engagement
- Assessment
  - Current and Historical
  - Physical and Behavioral
    - Medications
    - Screenings
    - Self-Management
    - Physical and Social Environment

Comprehensive Care Management Cont.

- Care Plan
  - Person Centered
  - Wraparound Planning
- Monthly Care Gaps reporting
- Monitoring
- Continuity of Care Document

Information Technology

- Portal
  - Member Portal / Patient 360
- Reporting
  - Gaps in Care / Score Cards
- Provider tools
  - Health and Wellness
  - Health Screenings

Team Role: Comprehensive Care Management

Designated Practitioner

Nurse Care Coordinator can assist.

CARE COORDINATION

Care Coordination

- Implementation of Person Centered Plan
- Outreach and Engagement
- Monitoring of Progress
- Referrals
- Follow up
- Arranging care for all stages of life
  - Acute, Chronic, Preventive, LTC and End of Life Care.

Care Coordination, con't.

- Health Information Technology
  - Mental Health
  - Oral Health
  - LTC
    - Transitional and Follow Up
  - Chronic Disease Management
  - Recovery and Social Services
  - Behavioral Modification Interventions
    - Tobacco, Health Coaching

Formal Assessment vs. Informal Assessment

FORMAL	INFORMAL

• Standardized format
  • Administration
  • Scoring
  • Quantitative
• Individual – based
• Evidence – based
	• Subjective
	• Qualitative
	• Individual or group basis

• **Patient Tier Assessment Tool (PTAT)** required for CCHH members • PHQ – 9 • PHQ – 2 • AUDIT (Alcohol Use Disorders Identification Test) • Vanderbilt Diagnostic Rating Scales • BDI (Becks Depression Screen)	• Direct observation • Social patterns • Interest / abilities inventory • Strengths / weaknesses • Checklists • Questionnaires • Interviews with member / family • Rating scales

Department of HUMAN SERVICES

Chronic Health Home Program
Patient Tier Assignment Tool (PTAT)
Version 4.0

Patient Full Name	Primary Care Provider
Medicaid ID #	Date of Assessment
Date Enrollment Request Submitted to IMPA	Date Note Entered in Patients Chart

Step 1: Eligibility Identification

1. Check the chronic condition box if the patient has any of the qualifying chronic conditions. If the patient has two or more qualifying conditions, they are eligible.
2. If the patient has only one chronic condition, check the at risk box if the patient has conditions that make them at risk for any of the qualifying conditions. Use examples in the guide to assist.

QUALIFYING CONDITIONS	CHRONIC CONDITION	AT RISK of CHRONIC CONDITION
Mental Health	☐	☐
Substance Use Disorder	☐	☐
Asthma	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
Overweight (BMI >25 or 85 percentile)	☐	☐
Hypertension	☐	☐
Chronic Back Pain	☐	☐
Chronic Obstructive Pulmonary Disease	☐	☐
TOTAL		
ELIGIBLE	☐ YES	☐ NO
If there are at least two chronic conditions or if there is one chronic condition and at least one at risk condition, the patient is eligible for a health home.		

How to use the PTAT:

Identify conditions that are **“chronic”:**

- Lasted at least 6 months
- Can reasonably be expected to continue for at least 6 months
- Are likely to recur

Eligibility criteria:

Member has:

- At least 2 chronic conditions, OR
- 1 chronic condition AND at least 1 “at risk for” condition

Step 2: Tier Assignment

1. Enter the diagnosis codes for any chronic condition that applies to the condition category. Utilize the Expanded Diagnosis Clusters (EDCs) to assist you with the determination if a condition is appropriate. Do not enter EDC codes but the diagnosis code.
2. Check the box in the chronic condition category for any category that has an identified diagnosis code entered.
3. Check the box in the condition is severe if the identified chronic condition is likely to become worse without additional intervention.

Condition Categories	Diagnosis Codes	Chronic Condition	Condition is Severe
Admin		☐	☐
Allergy, Asthma		☐	☐
Cardiovascular		☐	☐
Dental		☐	☐
Ear, Nose, Throat		☐	☐
Endocrine		☐	☐
Eye		☐	☐
Female Reproductive		☐	☐
Gastrointestinal/Hepatic		☐	☐
General Signs and Symptoms		☐	☐
General Surgery		☐	☐
Genetic		☐	☐
Genito-urinary		☐	☐
Hematologic		☐	☐
Infections		☐	☐
Malignancies		☐	☐
Musculoskeletal		☐	☐
Neonatal		☐	☐
Neurologic		☐	☐
Nutrition		☐	☐
Psychosocial/Mental Health		☐	☐
Reconstructive		☐	☐
Renal		☐	☐
Respiratory		☐	☐
Rheumatologic		☐	☐
Skin		☐	☐
Toxic Effects and Adverse Events		☐	☐
	Tier Assignment: 1-3 Tier 1 4-6 Tier 2 7-9 Tier 3 10 or more Tier 4		Total Severe Conditions

https://dhs.iowa.gov/sites/default/files/470-5267_2.pdf?022220211514

Appendix A

Expanded Diagnosis Clusters (EDCs), Adapted from The Johns Hopkins ACG System Reference Manual, Version 8.2 Page 1 of 3

Allergy ALL01 Allergic reactions ALL03 Allergic rhinitis ALL04 Asthma, w/o status asthmaticus ALL05 Asthma, with status asthmaticus ALL06 Disorders of the immune system	**Cardiovascular** CAR01 Cardiovascular signs and symptoms CAR03 Ischemic heart disease (excluding acute myocardial infarction) CAR04 Congenital heart disease CAR05 Congestive heart failure CAR06 Cardiac valve disorders CAR07 Cardiomyopathy CAR08 Heart murmur CAR09 Cardiac arrhythmia CAR10 Generalized atherosclerosis CAR11 Disorders of lipoid metabolism CAR12 Acute myocardial infarction CAR13 Cardiac arrest, shock CAR14 Hypertension, w/o major complications CAR15 Hypertension, with major complications CAR16 Cardiovascular disorders, other	**Dental** DEN01 Disorders of mouth DEN02 Disorders of teeth DEN03 Gingivitis DEN04 Stomatitis	**Ear, Nose, Throat** EAR01 Otitis media EAR02 Tinnitus EAR03 Temporomandibular joint disease EAR04 Foreign body in ears, nose, or throat EAR05 Deviated nasal septum EAR06 Otitis externa EAR07 Wax in ear EAR08 Deafness, hearing loss EAR09 Chronic pharyngitis and tonsillitis EAR10 Epistaxis EAR11 Acute upper respiratory tract infection EAR12 ENT disorders, other
Endocrine END02 Osteoporosis END03 Short stature END04 Thyroid disease END05 Other endocrine disorders END06 Type 2 diabetes, w/o complication END07 Type 2 diabetes, w/ complication END08 Type 1 diabetes, w/o complication END09 Type 1 diabetes, w/ complication	**Eye** EYE01 Ophthalmic signs and symptoms EYE02 Blindness EYE03 Retinal disorders (excluding diabetic retinopathy) EYE04 Disorders of the eyelid and lacrimal duct EYE05 Refractive errors EYE06 Cataract, aphakia EYE07 Conjunctivitis, keratitis EYE08 Glaucoma EYE09 Infections of eyelid EYE10 Foreign body in eye EYE11 Strabismus, amblyopia EYE12 Traumatic injuries of eye EYE13 Diabetic retinopathy EYE14 Eye, other disorders	**Female Reproductive** FRE01 Pregnancy and delivery uncomplicated FRE02 Female genital symptoms FRE03 Endometriosis FRE04 Pregnancy and delivery with complications FRE05 Female infertility FRE06 Abnormal pap smear FRE07 Ovarian cyst FRE08 Vaginitis, vulvitis, cervicitis FRE09 Menstrual disorders FRE10 Contraception FRE11 Menopausal symptoms FRE12 Utero-vaginal prolapse FRE13 Female gynecologic conditions other. NOTE: *Because of the "chronic" definition of six months or more, a complicated pregnancy that meets the criteria of severe, chronic, and requires a care team could be counted - at least for the duration of the pregnancy.*	**Gastrointestinal/Hepatic** GAS01 Gastrointestinal signs and symptoms GAS02 Inflammatory bowel disease GAS03 Constipation GAS04 Acute hepatitis GAS05 Chronic liver disease GAS06 Peptic ulcer disease GAS07 Gastroenteritis GAS08 Gastroesophageal reflux GAS09 Irritable bowel syndrome GAS10 Diverticular disease of colon GAS11 Acute pancreatitis GAS12 Chronic pancreatitis GAS13 Lactose intolerance GAS14 Gastrointestinal/Hepatic disorders, other

Team Role: Care Coordination

Nurse care coordinator

Assisted by entire health home team

HEALTH PROMOTION

Health Promotion

- Promotion
  - Health Goals
  - Prevention
    - Substance Abuse
    - Smoking
    - Obesity
    - Chronic Conditions
- Tools
  - Motivational Interviewing
  - Promoting Independence
  - Educating Member and Family
  - Increase Health Literacy
  - Self Management

Team Role: Health Promotion

Health coach

Designated Practitioner role

COMPREHENSIVE TRANSITION OF CARE

Transition of Care

Relationships

- Hospitals
- Community
- Other Institutions

Communication

- Discharge Planning
- Follow up
- Medication
- Care Planning
- Transferring due to age.

Team Role: Transitions of Care

Care Coordinator

Designated Practitioner

Assistance of the Health Coach

INDIVIDUAL & FAMILY SUPPORT

Individual and Family Support

- Education
  - Concerns
  - Self-Management
  - Medications
- Advocating
- Assessing
  - Physical / Social Needs, Strengths, Preferences and Risks

Team Role: Individual and Family Support

Health Coach

REFERRAL TO COMMUNITY & SOCIAL SUPPORT SERVICES

Supporting Members and Families

- Referral
- Coordinating
  - Health Care Program
  - Benefits
  - Housing
  - Recovery
  - Social Health

Team Role: Referral to Community & Social Support Services

- Designated Care Coordinator
  - Assistance from Health Coach

Q & A

Thank you!